FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028787

Facility Name: Taylorville Care Center

Address: 600 South Houston (Number) Taylorville (City) 62568 (Zip Code)

County: Christian

Telephone Number: (217) 824-9636 **Fax #** (618) 824-2472

IDPA ID Number: 37-11060662

Date of Initial License for Current Owners: 08/01/1984

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) Compilation Report Attached (Date)

(Print Name and Title) Cindy A. Tefteller

(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 East Center Drive, Alton, IL 62002

(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,777	923	4,329	7,029	8
9	SNF/PED					9
10	ICF	18,053	7,191		25,244	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,830	8,114	4,329	32,273	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.22%

D. How many bed-hold days during this year were paid by the Department?
13 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/01/1984

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/1984 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 24 and days of care provided 4,329

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Taylorville Care Center # 0028787 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	135,842	10,040	8,809	154,691		154,691		154,691			1
2	Food Purchase		141,029		141,029		141,029	(2,419)	138,610			2
3	Housekeeping	72,551	17,302		89,853		89,853		89,853			3
4	Laundry	60,421	18,666		79,087		79,087		79,087			4
5	Heat and Other Utilities			89,971	89,971		89,971	898	90,869			5
6	Maintenance	66,671	49,548	2,475	118,694		118,694	23,454	142,148			6
7	Other (specify):* Sanitation Services			9,095	9,095		9,095		9,095			7
8	**TOTAL General Services**	335,485	236,585	110,350	682,420		682,420	21,933	704,353			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,289,972	91,052	8,289	1,389,313		1,389,313	(837)	1,388,476			10
10a	Therapy			536,183	536,183		536,183		536,183			10a
11	Activities	33,941	3,636	4,390	41,967		41,967		41,967			11
12	Social Services	43,043			43,043		43,043		43,043			12
13	CNA Training											13
14	Program Transportation		2,302		2,302		2,302		2,302			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,366,956	96,990	558,462	2,022,408		2,022,408	(837)	2,021,571			16
	C. General Administration											
17	Administrative	58,729	9,882	190,000	258,611	(2,880)	255,731	(88,016)	167,715			17
18	Directors Fees											18
19	Professional Services			11,361	11,361		11,361	7,695	19,056			19
20	Dues, Fees, Subscriptions & Promotions			6,942	6,942	2,580	9,522	(4,943)	4,579			20
21	Clerical & General Office Expenses	19,689	13,910	27,035	60,634		60,634	27,921	88,555			21
22	Employee Benefits & Payroll Taxes			303,711	303,711	300	304,011	16,497	320,508			22
23	Inservice Training & Education			1,807	1,807		1,807		1,807			23
24	Travel and Seminar			508	508		508		508			24
25	Other Admin. Staff Transportation							2,545	2,545			25
26	Insurance-Prop.Liab.Malpractice			48,524	48,524		48,524	6,500	55,024			26
27	Other (specify):*											27
28	**TOTAL General Administration**	78,418	23,792	589,888	692,098		692,098	(31,801)	660,297			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,780,859	357,367	1,258,700	3,396,926		3,396,926	(10,705)	3,386,221			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Taylorville Care Center #0028787 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			41,599	41,599		41,599	69,992	111,591			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							46,669	46,669			33
34	Rent-Facility & Grounds			277,800	277,800		277,800	(277,800)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			319,399	319,399		319,399	(161,139)	158,260			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		137,262	12,567	149,829		149,829		149,829			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		137,262	66,222	203,484		203,484		203,484			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,780,859	494,629	1,644,321	3,919,809		3,919,809	(171,844)	3,747,965			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(892)	6		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,419)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,449)	17		19
20	Contributions	(1,100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,962)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(11,715)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,703)	VAR		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (26,240)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(145,604)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (145,604)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (171,844)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS **Page 5A**

Taylorville Care Center

ID# **0028787**

Report Period Beginning: **01/01/2005**

Ending: **12/31/2005**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Record deferred maintenance fees	$ 104	6	1
2	Record 2005 computer maint paid in 2004	2,748	6	2
3	Eliminate 2006 IDPH license paid in 2005	(995)	20	3
4	Eliminate civic dues	(369)	17	4
5	Depr on items required to be capitalized for cost rpt	227	30	5
6	Offset insurance settlement	(3,581)	6	6
7	Offset refunds	(837)	10	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,703)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Taylorville Care Center # 0028787 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,419)	0	0	0	0	0	0	0	0	0	0	(2,419)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	898	0	0	0	0	0	0	0	0	0	898	5
6	Maintenance	(1,621)	25,075	0	0	0	0	0	0	0	0	0	23,454	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,040)	25,973	0	0	0	0	0	0	0	0	0	21,933	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(837)	0	0	0	0	0	0	0	0	0	0	(837)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(837)	0	0	0	0	0	0	0	0	0	0	(837)	16
	C. General Administration													
17	Administrative	(4,818)	(83,198)	0	0	0	0	0	0	0	0	0	(88,016)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,695	0	0	0	0	0	0	0	0	0	7,695	19
20	Fees, Subscriptions & Promotions	(5,057)	114	0	0	0	0	0	0	0	0	0	(4,943)	20
21	Clerical & General Office Expenses	(11,715)	39,636	0	0	0	0	0	0	0	0	0	27,921	21
22	Employee Benefits & Payroll Taxes	0	16,497	0	0	0	0	0	0	0	0	0	16,497	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	2,545	0	0	0	0	0	0	0	0	0	2,545	25
26	Insurance-Prop.Liab.Malpractice	0	2,191	4,309	0	0	0	0	0	0	0	0	6,500	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(21,590)	(14,520)	4,309	0	0	0	0	0	0	0	0	(31,801)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,467)	11,453	4,309	0	0	0	0	0	0	0	0	(10,705)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Taylorville Care Center **#** 0028787 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	227	7,365	62,400	0	0	0	0	0	0	0	0	69,992	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	746	45,923	0	0	0	0	0	0	0	0	46,669	33
34	Rent-Facility & Grounds	0	0	(277,800)	0	0	0	0	0	0	0	0	(277,800)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	227	8,111	(169,477)	0	0	0	0	0	0	0	0	(161,139)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(26,240)	19,564	(165,168)	0	0	0	0	0	0	0	0	(171,844)	45

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jerry & Marilyn King	100.00	Mt. Vernon Countryside Manor, Inc.	Mt. Vernon	King Management	Nashville	Home Office
Jerry & Marilyn King	100.00	Aviston Countryside Manor, Inc.	Aviston			
Jerry & Marilyn King	100.00	Golden Manor Nursing Home, Inc.	Nokomis			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	See Schedule VIII	$	King Management Co.	100.00%	$ 898	$ 898	1
2	V	6	See Schedule VIII		King Management Co.	100.00%	25,075	25,075	2
3	V	17	See Schedule VIII	190,000	King Management Co.	100.00%	106,802	(83,198)	3
4	V	19	See Schedule VIII		King Management Co.	100.00%	7,695	7,695	4
5	V	20	See Schedule VIII		King Management Co.	100.00%	114	114	5
6	V	21	See Schedule VIII		King Management Co.	100.00%	39,636	39,636	6
7	V	22	See Schedule VIII		King Management Co.	100.00%	16,497	16,497	7
8	V	25	See Schedule VIII		King Management Co.	100.00%	2,545	2,545	8
9	V	26	See Schedule VIII		King Management Co.	100.00%	2,191	2,191	9
10	V	30	See Schedule VIII		King Management Co.	100.00%	7,365	7,365	10
11	V	33	See Schedule VIII		King Management Co.	100.00%	746	746	11
12	V								12
13	V								13
14	Total			$ 190,000			$ 209,564	$ * 19,564	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent - Facility & Grounds	$ 277,800	Jerry & Marilyn King	100.00%	$	$ (277,800)	15
16	V	26	Insurance		Jerry & Marilyn King	100.00%	4,309	4,309	16
17	V	30	Depreciation		Jerry & Marilyn King	100.00%	62,400	62,400	17
18	V	33	Real Estate Taxes		Jerry & Marilyn King	100.00%	45,923	45,923	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 277,800			$ 112,632	$ * (165,168)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jerry King	Owner	Mgmt/Consultant	100.00	84,204	16	26.94	Salary	$ 31,047	17, 8	1
2	Denise King	Regional Director	Administrative	0.00	198,137	16	26.94	Salary	73,056	17, 8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00	55,688	13	26.94	Salary	20,533	6, 8	3
4	Leslie Pedtke	Administrator	Administrative	0.00	192,523	0	0.00	Salary	0	N/A	4
5	Elizabeth King	Dietary	Dietary	0.00	1,536	0	0.00	Salary	0	N/A	5
6	Marilyn King	Owner	Mgmt/Consultant	100.00	2,922	1	26.94	Salary	1,078	17,8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 125,714		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: King Management Company, Inc.
Street Address: 935 South Mill Street
City / State / Zip Code: Nashville, IL 62263
Phone Number: (618) 327-3064
Fax Number: (618) 327-3083

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	119,775	4	$ 3,332	$	32,266	$ 898	1
2	6	Maintenance	Patient Days	119,775	4	93,082	76,221	32,266	25,075	2
3	17	Administrative	Patient Days	119,775	4	396,462	390,444	32,266	106,802	3
4	19	Professional Fees	Patient Days	119,775	4	28,564		32,266	7,695	4
5	20	Dues, Fees & Subscriptions	Patient Days	119,775	4	423		32,266	114	5
6	21	Clerical & Office Expense	Patient Days	119,775	4	147,133	129,122	32,266	39,636	6
7	22	Employee Benefits	Patient Days	119,775	4	61,240		32,266	16,497	7
8	25	Other Admin. Staff Transport	Patient Days	119,775	4	9,447		32,266	2,545	8
9	26	Insurance	Patient Days	119,775	4	8,135		32,266	2,191	9
10	30	Depreciation-Copiers	Direct Costs	N/A	1	679		N/A		10
11	30	Depreciation-Other	Patient Days	119,775	4	13,420		32,266	3,615	11
12	30	Depreciation-Vehicles	Patient Days	119,775	4	13,920		32,266	3,750	12
13	33	Real Estate Taxes	Patient Days	119,775	4	2,771		32,266	746	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 778,608	$ 595,787		$ 209,564	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Schedule Not Applicable						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Taylorville Care Center # 0028787 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 36,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 40,123	2
3. Under or (over) accrual (line 2 minus line 1).	$ 3,923	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 42,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 45,923	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	34,482	8
2001	35,441	9
2002	36,902	10
2003	38,242	11
2004	40,123	12

Line 2: Real Estate Taxes paid are for the 2004 tax year.

Line 7: $45,923 Real Estate Tax
746 Home office allocation
$46,669 Total Real Estate Tax Schedule V, Line 33

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Taylorville Care Center COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0028787

CONTACT PERSON REGARDING THIS REPORT Linda Peppenhorst

TELEPHONE (618) 327-3064 FAX #: (618) 327-3083

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-13-28-401-005	Cheneys Add Lts 1 thru 6 Blk 3 &	$ 40,122.58	$ 40,122.58
2.		Lts 1 thru 6 Blk 4 & OL 1 & Vac	$	$
3.		Austin St. & Alley	$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 40,122.58	$ 40,122.58

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,610 B. General Construction Type: Exterior Brick Frame Non-Comb. Sprinkle Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Taylorville Estates is a 49 unit (27,945 square foot) retirement center which is located on the property adjacent to Taylorville Care Center

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	98 Bed Nursing Home	186,200	1984	$ 40,000	1
2	Home Office Land		1989	1,694	2
3	TOTALS	186,200		$ 41,694	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1984	1974	$ 1,560,000	$	25	$ 62,400	$ 62,400	$ 1,341,817	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	80 Gallon Water Fixture			1985	1,581		10			1,581	9
10	Improvements to Building			1985	12,510	500	25	500		10,009	10
11	Improvements to Parking Lot			1986	1,184		10			1,184	11
12	New Light Fixtures			1987	997		10			997	12
13	Tile Floor			1987	5,941	141	10		(141)	5,941	13
14	Roof			1988	55,100		10			55,100	14
15	Addition to Alarm System			1988	5,610		10			5,610	15
16	Concrete Driveway			1989	2,729		15			2,729	16
17	Nurse's Station			1991	4,809		15	321	321	4,703	17
18	Water Heater			1993	3,750	250	15	250		3,208	18
19	Air conditioner			1993	2,800		10			2,800	19
20	New Office			1993	1,500	38	40	38		450	20
21	4" Backflow Preventer			1994	3,966	159	25	159		1,904	21
22	Carpeting			1994	2,471		10			2,471	22
23	Circulating Pump on Water Heater			1994	2,450	175	14	175		1,969	23
24	Fence			1995	3,590	239	15	239		2,533	24
25	Water Heater			1995	1,602	107	15	107		1,166	25
26	Sprinkler Heads			1995	1,600	107	15	107		1,076	26
27	New Roof			1996	25,000	2,500	10	2,500		23,542	27
28	Water Softener			1996	5,908	492	12	492		4,595	28
29	Ceramic Tile			1997	5,167	517	10	517		4,608	29
30	Garage			1997	7,841	784	10	784		6,665	30
31	Rooftop A/C, Ducts and Gas Lines			1997	10,940	1,094	10	1,094		9,299	31
32	Beauty Shop Addition			1997	6,823	455	15	455		3,639	32
33	Carpeting			1998	4,154	415	10	415		3,184	33
34	Windows			1998	5,681	568	10	568		4,260	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Heating and A/C Units	1998	$ 4,128	$	5	$	$	$ 4,128	37
38	Air Conditioner Units	1999	25,051	2,505	10	2,505		16,492	38
39	Rear Parking Lot/Driveway	1999	2,995	299	10	299		1,872	39
40	Air Conditioner Units	2000	4,834	483	10	483		2,578	40
41	Landscaping	2001	2,300	230	10	230		997	41
42	Electrical	2001	6,725	672	10	672		3,250	42
43	Cabinets	2001	27,445	1,372	20	1,372		6,518	43
44	Water Heater	2001	5,800	387	15	387		1,740	44
45	Wallpaper & Installation	2002	9,016	1,803	5	1,803		6,612	45
46	Wallguards	2002	5,729	382	15	382		1,432	46
47	Water Heater	2002	6,759	451	15	451		1,465	47
48	Carpet/baseboard Remodel	2002	16,561	1,656	10	1,656		6,210	48
49	Landscaping	2004	5,106	511	10	511		638	49
50	20' Gazebo	2004	24,761	1,651	15	1,651		2,063	50
51	Parking Lot	2004	27,200	3,400	8	3,400		4,250	51
52	Lawn Sprinkler System	2004	3,850	257	15	257		342	52
53	Landscaping	2004	8,977	898	10	898		1,047	53
54	Vinyl Fence	2004	5,219	522	10	522		565	54
55	Facility Sign	2004	2,632	263	10	263		351	55
56	100 Gallon Water Heater	2004	2,390	239	10	239		339	56
57	Sidewalk	2004	1,920	128	15	128		171	57
58	Telephone System	2004	4,337	434	10	434		470	58
59	Concrete Sidewalk	2005	3,100	52	20	52		52	59
60									60
61	Home Office Parking Lot	1989	532		10			532	61
62	Home Office Building	1995	26,408		25	1,056	1,056	10,739	62
63	Home Office Interior Finishes Lower Level	1996	1,638		15	109	109	1,037	63
64	Home Office Carpet	1996	573		5			573	64
65	Home Office Cabinets	1996	906		20	45	45	430	65
66	Home Office Electrical	1996	314		15	21	21	199	66
67	Home Office Front Door	2002	431		10	43	43	140	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,983,341	$ 27,136		$ 90,990	$ 63,854	$ 1,584,272	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 91,640	$ 8,719	$ 10,987	$ 2,268	5-15 yrs	$ 45,066	71
72	Current Year Purchases	6,746	650	770	120	15 yrs	770	72
73	Fully Depreciated Assets	274,571					274,571	73
74								74
75	TOTALS	$ 372,957	$ 9,369	$ 11,757	$ 2,388		$ 320,407	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Home Office Vehicle	2002 Ford F150 P/U	2002	$ 3,822	$	$ 956	$ 956	4	$ 3,503	76
77	Home Office Vehicle	2004 Lexus RX 330	2003	11,178		2,794	2,794	4	6,986	77
78	Facility Business	1994 Chevy Van	1995	13,590				4	13,590	78
79	Facility Business	2003 Ford Supreme Bus	2003	20,375	5,094	5,094		4	10,612	79
80	TOTALS			$ 48,965	$ 5,094	$ 8,844	$ 3,750		$ 34,691	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,446,957	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 41,599	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 111,591	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 69,992	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,939,370	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? N/A YES N/A NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$ None

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	10,295	$ 211,511	$	10,295	$ 211,511	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		4,285	109,682		4,285	109,682	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		10,731	214,990		10,731	214,990	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 2	# of prescrpts				137,262		137,262	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Amb, Lab & X-Ray	39, 3				12,567			12,567	13
14	TOTAL			$	25,311	$ 548,750	$ 137,262	25,311	$ 686,012	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center **#** 0028787 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 581,280	$	1
2	Cash-Patient Deposits	2,716		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	392,261		3
4	Supply Inventory (priced at cost)	5,352		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Investment in LTC insurance	32,340		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,013,949	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	320,005		15
16	Equipment, at Historical Cost	378,669		16
17	Accumulated Depreciation (book methods)	(480,484)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 218,190	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,232,139	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 186,837	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,716		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	146,276		30
31	Accrued Taxes Payable (excluding real estate taxes)	30,226		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 366,055	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 366,055	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 866,084	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,232,139	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 938,981	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 938,981	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	581,900	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(654,797)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (72,897)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 866,084	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,549,268	1
2	Discounts and Allowances for all Levels	(845,834)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,703,434	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	772,593	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 772,593	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,748	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,748	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,076	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,076	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	13,002	28
28a	Diapers	1,856	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 14,858	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,501,709	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	682,420	31
32	Health Care	2,022,408	32
33	General Administration	692,098	33
	B. Capital Expense		
34	Ownership	319,399	34
	C. Ancillary Expense		
35	Special Cost Centers	149,829	35
36	Provider Participation Fee	53,655	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,919,809	40
41	**Income before Income Taxes (line 30 minus line 40)****	581,900	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 581,900	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** no **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,733	1,998	$ 51,234	$ 25.64	1
2	Assistant Director of Nursing	2,201	2,454	44,613	18.18	2
3	Registered Nurses	7,357	7,774	151,566	19.50	3
4	Licensed Practical Nurses	22,823	23,957	348,400	14.54	4
5	CNAs & Orderlies	66,403	66,403	675,190	10.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,913	4,138	33,941	8.20	10
11	Social Service Workers	4,043	4,267	43,043	10.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,961	17,985	135,842	7.55	15
16	Dishwashers					16
17	Maintenance Workers	4,158	4,602	66,671	14.49	17
18	Housekeepers	8,712	9,600	72,551	7.56	18
19	Laundry	8,091	8,334	60,421	7.25	19
20	Administrator	1,843	2,115	58,729	27.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,013	2,059	19,689	9.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,882	1,999	18,969	9.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,133	157,685	$ 1,780,859 *	$ 11.29	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	165	$ 8,062	1, 3	35
36	Medical Director	contract	9,600	9, 3	36
37	Medical Records Consultant	16	1,052	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	contract	1,283	10, 3	39
40	Physical Therapy Consultant	119	5,954	10, 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	90	4,390	11, 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	390	$ 30,341		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ Section N/A		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jaqueline Carpenter	Administrator	0	$ 58,729
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,729

B. Administrative - Other

Description	Amount
Management Fees	$ 190,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 190,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accounting	$ 9,950
Greenfelder, Hemker, & Gale	Legal	1,411
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 11,361

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 100,130
Unemployment Compensation Insurance	37,552
FICA Taxes	134,343
Employee Health Insurance	29,299
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	1,302
Employee Physicals	1,085
Employee Christmas Party	300
Home Office Allocation	16,497
TOTAL (agree to Schedule V, line 22, col.8)	$ 320,508

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	678
Health Care Worker Background Check	
(Indicate # of checks performed 19)	304
Dues & Subscriptions	1,001
Home Office Dues & Subscriptions	114
Franchise Tax	100
Misc. Licenses and Fees	387
Resident Background Checks	1,000
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,579

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	508
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 508

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Wallpapering	2/2002	$ 1,878	3 YRS.	$ 522	$ 626	$ 626	$ 104	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,878		$ 522	$ 626	$ 626	$ 104	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,973** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **53,655**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **None** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation. No
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **47%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

TAYLORVILLE CARE CENTER
RECLASSIFICATIONS
12/31/05

DESCRIPTION	SCHED V LINE #	INCREASE (DECREASE)
FEES & SUBSCRIPTIONS	20	2,580
EMPLOYEE BENEFITS & PAYROLL TAXES	22	300
ADMINISTRATIVE	17	(2,880)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISCELLANEOUS EXPENSE TO THE CORRECT LINES:		
BACKGROUND CHECKS	$ 304	
RESIDENT BACKGROUND CHECKS	1,000	
MISC LICENSES & FEES	355	
DUES	190	
EMPLOYEE PARTY	300	
SUBSCRIPTIONS	631	
FRANCHISE TAX	100	
TOTAL	2,880	